Petition

81-1423

Case No. ———

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

MAY V. WILSON,

Petitioner,

v.

Robert G. Renner, United States District Judge for the District of Minnesota
(MUTUAL OF OMAHA INSURANCE COMPANY, Real Party in Interest)

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT

PETERSON, ENGBERG & PETERSON
By Roger A. Peterson
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QUESTIONS PRESENTED

1. Whether the District Court has the power to order Petitioner to submit to a mental exam when Respondent's right to require such an exam has contractually terminated.
2. Whether the District Court's order constitutes a clear abuse of discretion.

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IN THE

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MAY V. WILSON,

Petitioner,

vs.

MUTUAL OF OMAHA INSURANCE COMPANY,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT

QUESTIONS PRESENTED

In a suit for breach of contract and fraudulent misrepresentation, Petitioner seeks to collect fixed daily hospital benefits for two psychiatric hospitalizations, one from September 5, 1977 to October 21, 1977, and a second from April 13, 1978 to June 9, 1978. In May, 1981, Respondent moved the Court for an order compelling Petitioner to submit to an adverse medical examination. Petitioner opposed the motion on the grounds that the insurance contract permits the insurance company to require an exam only prior to denial of the claim, and the District Court has no power to order an exam at this time,

that these hospitalizations were now over three years old and her current psychiatric condition is not an issue, that her psychiatric condition is a sensitive personal matter which ought not to be lightly invaded until Respondent has exhausted other reasonable courses of discovery relevant to the very limited medical issues and that Respondent has not shown good cause for the examination at this time. The District Court entered a broad order requiring Petitioner to submit to a mental examination, but failed to specify limitations required by Rule 35 of the Federal Rules of Civil Procedure. The United States Court of Appeals for the Eighth Circuit denied mandamus.

The questions presented are:

1. Whether the District Court has power to order Petitioner to submit to a mental exam when Respondent's right to require such an exam has contractually terminated.
2. Whether the District Court's order constitutes a clear abuse of discretion.

PARTIES

All parties are named in the caption of the case.

OFFICIAL AND UNOFFICIAL REPORTS

None published.

JURISDICTION

On June 18, 1981, Magistrate Earl Cudd granted Respondent's Motion to compel Petitioner to be examined by Respondent's psychiatrist.

Petitioner appealed from that Order and the appeal was denied by Judge Robert Renner on July 23, 1981.

Petitioner sought mandamus from the Eighth Circuit Court of Appeals which was denied on November 19, 1981, and filed November 24, 1981.

The Jurisdiction of this Court is invoked under 28 U.S.C. 1254(1) and 28 U.S.C. 2101(2).

STATUTES

Rule 35(a) Federal Rules of Civil Procedure:

> Rule 35. Physical and Mental Examination of Persons
>
> (a) ORDER FOR EXAMINATION. When the mental or physical condition (including the blood group) of a party, or a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control. The order may be made only on motion for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made.

STATEMENT OF THE CASE

Petitioner, knowing she was chronically ill, and having been subjected to lengthy hospitalizations, began to purchase daily hospital benefit policies through the mails. Three of the policies were issued by Respondent. These are group policies which provide for guaranteed acceptance,

and, after a waiting period, they cover pre-existing conditions. Each policy pays a fixed amount for each day of hospitalization if:

a. The Insured is sick, and

b. Inpatient hospitalization is reasonably required. Certain types of sickness are excluded but none are relevant in this action. The policies require that the treating doctor be a qualified physician, and that the hospital be a general medical hospital.

Petitioner had three policies with Respondent, Mutual of Omaha Insurance Company. Each one was a group policy through her memberships in the American Automobile Association, the Air Force Association, and the National Association for Uniformed Services.

This claim involves two hospitalizations. One occurred from September 5, 1977 to October 21, 1977, and the second was from April 13, 1978 to June 9, 1978. Both hospitalizations were at the Metropolitan Medical Center, a major hospital in downtown Minneapolis, Minnesota. Both hospitalizations were under the care of Dr. Randall Lakosky, a practicing psychiatrist in Minneapolis, Minnesota. Respondent was timely notified of the hospitalizations, but at no time during the pendency of Respondent's consideration of these claims did it request that Petitioner submit to an adverse medical exam. Both claims were considered and denied without the company exercising its right to an exam. The general provisions of the contract provide:

> "8. Physical Examinations and Autopsy: The Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of

claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

After commencement of this suit, by Motion on May 4, 1981, Respondent moved to require Petitioner to submit to an adverse psychiatric examination. Respondent's Motion and brief Affidavit are included in the Appendix. The Motion was granted by the U.S. Magistrate on June 18, 1981. That Order was appealed to the District Court on July 1, 1981, and affirmed on July 23, 1981. On October 16, 1981, Petitioner proceeded by mandamus to the United States Court of Appeals on the basis that there had been a clear abuse of discretion, and lack of jurisdiction in the District Court. On November 24, 1981, the Court of Appeals denied the Petition.

Petitioner now requests this Court grant certiorari to give the issues raised herein the serious consideration they deserve.

The basis for federal jurisdiction in the District Court was diversity and a matter in controversy exceeding the sum of Ten Thousand Dollars ($10,000).

REASONS WHY WRIT SHOULD ISSUE

1. ABSENCE OF POWER

Respondent has no right to request any examination at this time. The insurance contract clearly provides that the company shall have the right to reasonably require a physical examination "during the pendency of a claim hereunder". Respondent did not request an exam during that period, denied the claim, and now seeks to bootstrap

itself into an additional opportunity to have Petitioner examined by virtue of the fact that it forced her to bring a lawsuit to recover her damages. In *Finkelstein, et al. v. Equitable Life Assurance Society of the United States,* 256 App. Div. 593, 11 NYS2d 135 (1939), the Court disposed of the insurer's argument as follows:

> "The health policy gives Defendant the right to require the insured to submit to a further examination only during the pendency of a claim thereunder. The obvious purpose of these provisions is to permit Defendant to determine whether it should continue disability benefits either after it has accepted a claim or while a claim is pending unrejected. These provisions give Defendant no right to a physical examination after it has rejected the claim. Moreover, the life policies give Defendant only the right to demand "proof" of the continuance of the disability. This does not necessarily contemplate the insured's submission to a physical examination of the will of Defendant." 11 NYS2d at 138.

Respondent should not be permitted to use the Courts to create new or additional rights under the contract which it drafted. Such a result will encourage insurance companies to deny claims without adequate investigation, thinking that it can complete its investigation in any court proceedings that follow.

2. CLEAR ABUSE OF DISCRETION

The Orders of the District Court and Court of Appeals herein constitute a clear abuse of discretion. F.R.Civ.P. 35 requires the Court to specify the manner, conditions and scope of examination, but Respondent breached its af-

firmative duty to define the nature and scope of the examination requested. As a result, the District Court also did not specify the nature and scope of the examination required.

What is going to happen to Plaintiff in that doctor's office? What type of things does he *need* to inquire into? What types of things is he going to inquire into unless the Court specifies the conditions and scope of the examination? To what extent is he going to be permitted to inquire into personal intimate details that may be unrelated to Plaintiff's 1977 or 1978 hospitalizations?

Psychiatric conditions are sensitive, personal matters which have received increased attention and protection from our courts in recent years. For example, in situations involving treating psychiatrists, an insurer's right to inquire into the party's state of mind has been restricted in order to protect the personal, intimate relationship between a psychiatrist and his patient. The nature of the relationship is such that full patient-doctor disclosure and effective treatment cannot be obtained without assuring the patient that his revelation of intimate details will not be made available to third parties, without demonstration of substantial needs. In *Schlagenhauf v. Holder,* 379 U.S. 104, 85 Sup. Ct. 234 (1964), a writ of certiorari issued because movant failed to make an affirmative showing that each condition as to which examination was sought was really and genuinely in controversy *and* that good cause exists for ordering each particular examination. And in *Metropolitan Life Insurance Company v. Lehman,* 125 Ga. App. 539, 188 S.E.2d 393 (1972), the Court denied the insurer a right to a medical exam where the insurer could have obtained the desired information "by

other means", presumably through deposition questioning of a doctor who had examined the insured. See also *Marroni v. Matey*, 82 FRD 371 (1979), *Winters v. Travia*, 18 F.R.S. 2d 842 (1974).

Respondent has made no attempt to take the deposition of the treating doctor, nor has it met the requirements of *Schlagenhauf*. It has not made an affirmative showing of the aspects of Plaintiff's psychiatric condition as to which examination is sought, has not shown that it has no ability to obtain the desired information by other means, and has requested a blanket psychiatric exam evidently without limit as to the nature or scope of the examination.

Respondent had not undertaken a single step to obtain any medical discovery in this case in the form of medical records, medical reports, depositions of doctors, or any other medical discovery. It has not sought to limit the exam in any manner to make it relevant to the particular hospitalizations involved in this lawsuit. In fact, it's Affidavit in support of the motion did not even refer to the hospitalizations at issue in this suit.

It is incumbent upon the District Court to exercise some reasonable judgment at this stage in order to properly protect Petitioner and make appropriate provision as required by the Rule. The factual inquiry, to the extent that one exists, is whether or not a qualified doctor could reasonably conclude to treat Petitioner in a hospital. Petitioner bought these policies to provide coverage in the event that she was subjected to frequent or lengthy debilitating hospitalizations. Her coverage should not now be subjected to challenges based on the fact that some doctors would not have treated her in this same way. If

this was one reasonable way to treat her, then the coverage should follow. Petitioner cannot be required to obtain multiple medical opinions before agreeing to enter the hospital, in order to be assured that she will have the coverage which she purchased. *VanVactor v. Blue Cross Association*, 50 Ill. App. 3rd 709, 365 NE2d 638 (1977).

CONCLUSION

For the reasons set forth above, it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

PETERSON, ENGBERG & PETERSON
By Roger A. Peterson
Counsel for Petitioner
And Thomas W. Wexler
700 Title Insurance Building
Minneapolis, Minnesota 55401
(612) 338-6743

Appendix

APPENDIX

JUDGMENT

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

In Re: May V. Wilson,

Petitioner.

September Term, 1981

Petition for Writ of Mandamus

No. 81-2102

Petitioner's petition for writ of mandamus has been considered by the Court and is hereby denied.

Certified copies of judgment to issue forthwith.

November 19, 1981.

A True Copy:

ATTEST:

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

May V. Wilson,

Plaintiff,

vs.

Mutual of Omaha Insurance Company,

Defendant.

Order

Civ. 3-80-335

This matter comes before the Court on plaintiff's appeal from the June 18, 1981, Order of Magistrate J. Earl Cudd, granting defendant's motion to compel an adverse medical examination pursuant to Rule 35, F.R.Civ.P. Thomas Wexler, Esq., appears for plaintiff, and Robert Cragg, Esq., appears for defendant.

Following a hearing on defendant's motion, the Magistrate expressly found that plaintiff's mental condition is at issue in this action and that good cause had been shown for the examination. In this appeal, plaintiff, in essence, contends that these findings were clearly erroneous. She asserts that neither Rule 35 nor the insurance contract between the parties provide a basis for the Magistrate's Order.

Under Local Rule 14 B, this Court shall set aside, on appeal, only orders found to be clearly erroneous or contrary to law. Having review the briefs of counsel and all the files and records in this matter, the Court can-

not say that the Order of June 18 is clearly erroneous or contrary to law.

Accordingly,

IT IS HEREBY ORDERED that plaintiff's appeal is denied and that the Order of the Magistrate is affirmed.

Dated: July 23, 1981.

ROBERT G. RENNER
United States District Judge

Order

Civil 3-80-335

THOMAS W. WEXLER, ESQ., 400 Second Avenue South, RM 700, Minneapolis, MN 55401, appears for plaintiff;

ROBERT S. CRAGG, ESQ., 5353 Wayzata Boulevard, RM 500, Minneapolis, MN 55416, appears for defendant.

Before the Court is defendant's motion for a mental examination of plaintiff pursuant to Rule 35, F.R.Civ.P.

Based upon the briefs and arguments of counsel and all the files and records,

IT IS HEREBY ORDERED that defendant's motion is granted. Plaintiff shall submit to an examination by Dr. Carl Schwartz at a time and place to be agreed upon by the parties.

Date: June 18, 1981

J. EARL CUDD
United States Magistrate

The Court is satisfied that plaintiff's mental condition is at issue in this proceeding and that good cause has been shown for the examination.

Complaint

NOW COMES PLAINTIFF and for her complaint against the above-named Defendant, states and alleges that:

GENERAL ALLEGATIONS

1. Plaintiff, May V. Wilson, is a citizen of the State of Minnesota. Defendant, Mutual of Omaha Insurance Company, is a Nebraska corporation with its principal place of business in Omaha, Nebraska. The matter in controversy exceeds, exclusive of interests and costs, the sum of $10,000.00.

2. Defendant issued to Plaintiff three policies of group daily hospital benefit insurance which were in effect at all times material herein, and copies of which are attached hereto as Exhibits A through C respectively, for the following groups, to-wit:

a. American Automobile Association

b. Air Force Association

c. National Association for Uniformed Services

3. Plaintiff has paid full and adequate consideration for the policies.

4. May V. Wilson was hospitalized at Metropolitan Medical Center in Minneapolis, Minnesota, from September 5, 1977 to October 21, 1977, and pursuant to the terms of the policy attached hereto as Exhibit B, Defendant owes Plaintiff the sum of $2,760.00. Defendant has paid for this hospitalization on the other two policies.

5. Plaintiff was also hospitalized at Metropolitan

Medical Center from April 13, 1978 to June 9, 1978, and pursuant to the terms of all three policies, Defendant owes Plaintiff the additional sum of $9,425.52.

6. Plaintiff has requested payment, but Defendant has refused to pay.

FIRST CAUSE OF ACTION

7. Plaintiff realleges the general allegations above and incorporates them herein by this reference.

8. Defendant's failure and refusal to pay the benefits due under the policies is a breach of the contracts with Plaintiff as a result of which Plaintiff has incurred loss of the benefits due under the contracts in the sum of $12,185.52.

9. As a further natural and proximate result of Defendant's breach herein, Plaintiff has incurred foreseeable and substantial attorney's fees and costs of collection all to Plaintiff's damage in the approximate additional sum of $20,000.00.

WHEREFORE, Plaintiff requests judgment of this Court in the sum of Twelve Thousand One Hundred Eighty-Five and 52/100ths ($12,185.52) together with attorney's fees and costs in the approximate sum of $20,000.00 and her costs and disbursements herein.

SECOND CAUSE OF ACTION

10. Plaintiff realleges each of the foregoing allegations and incorporates them herein by this reference.

11. Defendant, individually and through its agents, advertised and issued said policies of insurance represent-

ing and emphasizing that said insurance would pay benefits regardless of any other insurance that Plaintiff may own.

12. In advertising and issuing said policies of insurance, Defendant also represented, maintained, and emphasized that all pre-existing illnesses would be covered after the coverage was in force for 24 consecutive months.

13. Each of said policies, at all times relevant herein, has been in force in excess of 24 consecutive months.

14. Said representations were made by Defendant for the purpose of inducing Plaintiff, and others like Plaintiff, to purchase insurance policies and other related insurance coverages.

15. Plaintiff relied on said representations as being true in purchasing said policies.

16. Defendant has now denied benefits based on the number of policies purchased by Plaintiff, and upon other alleged infirmities in the contracts.

17. Defendant has accepted premiums from Plaintiff with the full knowledge of the facts upon which the alleged infirmities of the contract are based, and upon which it has denied benefits.

18. Defendant's representations were intentionally false and fraudulent and were known by it to be false and fraudulent when they were made, or they were made with reckless disregard of their truth.

19. By virtue of said intentionally false and fraudulent and reckless conduct, Defendant is guilty of fraud in the inducement to enter such contracts, and Plaintiff is

entitled to punitive damages in a sum in excess of $50,-000.00.

WHEREFORE, Plaintiff requests judgment of this Court in the sum of Twelve Thousand One Hundred Eighty-Five and 52/100ths ($12,185.52) together with attorney's fees and costs in the approximate sum of $20,-000.00, and an additional sum in excess of $50,000.00 as punitive damages, together with her costs and disbursements herein.

Dated: May 27, 1980.

PETERSON, ENGBERG & PETERSON
THOMAS W. WEXLER
Attorneys for Plaintiff

Answer

Comes now Mutual of Omaha Insurance Company and for its Answer to the Plaintiff's Complaint:

I.

Denies each and every matter, allegation and thing contained in the Plaintiff's Complaint except as is hereinafter admitted or qualified.

II.

Denies subject matter jurisdiction.

III.

Alleges that the Plaintiff's Complaint fails to state a cause of action.

IV.

Alleges that Plaintiff is not the real party in interest and that the beneficial owner of the certificates does not have an insurable interest.

V.

Alleges that the certificates described in Plaintiff's Complaint were obtained pursuant to a scheme to profit by the purchase of multiple insurance policies and that the policies are, therefore, wager contracts and void as against public policy.

VI.

The validity of the certificates issued to Plaintiff in connection with her membership in the National Association

of Uniformed Services and the Air Force Association is pending in Hennepin County District Court in an action brought against Mutual of Omaha Insurance Company by Plaintiff.

VII.

Denies that the certificate sued upon by Plaintiff in connection with her membership in the American Automobile Association was issued by Defendant.

VIII.

Plaintiff is collaterally estopped by decisions in Hennepin County District Court and the United States District Court for the District of Minnesota from claiming attorneys fees or punitive damages.

IX.

Plaintiff has failed to comply with conditions precedent to recovery.

X.

Defendant hereby reiterates previous offers to rescind the certificates and refund to the Plaintiff premiums paid together with interest.

XI.

In the event that the certificates upon which suit is brought are valid, Defendant denies that any benefits are owing pursuant to the terms of the certificates.

WHEREFORE, Defendant prays Judgment that Plaintiff take nothing by her cause of action and that Defendant have Judgment for its costs and disbursements herein.

CRAGG & BAILLY
By ROBERT S. CRAGG
Attorneys for Defendant

Notice of Motion and Motion

TO: THE PLAINTIFF ABOVE NAMED AND HER ATTORNEY, THOMAS WEXLER, 700 TITLE INSURANCE BUILDING, MINNEAPOLIS, MINNESOTA 55401

PLEASE TAKE NOTICE that the undersigned will move the Court thereof to be held before Magistrate J. Earl Cudd on the 4th day of May, 1981, at 11:00 A.M., in Room 530 United States Courthouse, Minneapolis, Minnesota, for an order compelling the plaintiff to submit to an adverse medical examination pursuant to Rule 35.

Said Motion will be based upon the records, files and proceedings herein.

CRAGG & BAILLY, LTD.
By ROBERT S. CRAGG
Attorneys for Defendant

Affidavit

At one time, plaintiff, a retired nurse, had over 60 policies of "daily hospital indemnity" insurance. Each policy or certificate would pay so much per day in the hospital. Plaintiff has been frequently hospitalized for long periods of time. She has spent 98 days in a facility at Nogales, Mexico, and this is the subject of litigation pending in Hennepin County District Court. She has spent in excess of 100 days at facilities in Costa Rica and Guadalajara, Mexico. The defendant denies the necessity for hospitalization for the periods of time involved in this lawsuit and, in accordance with the language of the policy certificates and in accordance with Rule 35, scheduled plaintiff for an examination with a psychiatrist, Dr. Carl Schwartz. Plaintiff questioned whether she would attend such an examination and, therefore, this motion is being made. Defendant has selected a psychiatrist for this examination since plaintiff's treating physicians for the hospitalizations involved in this litigation were psychiatrists.

/s/ ROBERT S. CRAGG

Notarized April 8, 1981.

Notice of Appeal

TO: DEFENDANT, MUTUAL OF OMAHA, AND ROBERT CRAGG, ITS ATTORNEY

Please take notice that Plaintiff appeals the order of Magistrate Earl Cudd dated June 18, 1981, and filed June 22, 1981, requiring Plaintiff to submit to an examination by Dr. Carl Schwartz. The basis for the objection is:

1. Defendant has failed to show good cause for the examination;

2. Defendant has no right to the examination under the contract;

3. Defendant has waived its right to the examination;

4. A request for examination is untimely; and

5. Plaintiff's condition is not in controversy.

DATED: 7/1, 1981.

PETERSON, ENGBERG & PETERSON
THOMAS W. WEXLER
Attorney for Plaintiff

BENEFITS UP TO $60 PER DAY!
FAMILY PLANS AVAILABLE!
NEW SENIOR AGE BENEFITS! (for members 65 and over)*

NEW LARGER BENEFITS NOW IN EFFECT! YOU CAN RECEIVE UP TO $60 EACH DAY YOU ARE HOSPITALIZED!

Benefits begin on the first day you are hospitalized—for covered sickness and accidents—and continue for as long as 365 days. There is no deductible or waiting period, and *benefits are payable in addition to all other insurance or government benefits* you may receive.

THE COST OF BEING SICK

Hospital costs are literally skyrocketing. Authorities predict that the *average cost per hospital day may increase to $175* in the near future (in the past 5 years it has jumped from $54.27 to $87.45). This is why it makes sense to provide yourself and your family with extra tax-free protection against the growing direct and indirect costs of being hospitalized.

INDIRECT COSTS ADD UP, TOO

Even if you believe that your current hospitalization coverage is adequate, while you are in the hospital you may still have to meet such additional costs as a private room, special nursing care, or personal comfort items to make your stay more pleasant—costs you will normally have to pay out of your pocket. And, while this AFA Plan is not designed to pay for these specific services, benefits are payable directly to you, and *you may use the payments you receive for whatever you wish.* There is no restriction of any kind.

YOUR CHOICE OF PLANS

Under AFA's Program, you have three basic plans to choose from. You simply select the one which best meets your needs.

Individual plan . . . coverage for you;
Limited family plan . . . coverage for you and your wife;
Full family plan . . . coverage for you, your wife, and all of your dependent children.

Under each plan you have a choice of coverage . . . $20, $40, or $60 per day. Depending on the plan you select, your wife would receive 75% of your daily benefit and each child would receive 50% of your benefit. And, in all cases, benefit payments would be made for up to 365 days for each covered illness or accident for every member of your family.

ELIGIBILITY

All members of the Air Force Association who are citizens of the United States are eligible to become insured under this program. (For members Age 65 and over, see Senior Age Benefits information on next page.) Members of their families are also eligible for coverage; under the Full Family Plan, dependent children will be insured between the ages of 14 days and 19 years (unmarried children between the ages of 19 and 23 are also eligible if they are wholly dependent upon the principal insured for support and are attending school or college on a full-time basis).

PAYMENT OF BENEFITS

Benefit payments will begin on the day you (or other insured family members) are hospitalized and are payable for up to 365 days for each covered illness or accident . . . for each member of your family. *There is no deductible period.* If you are hospitalized, you should notify AFA as quickly as possible so that benefit checks can be sent without unnecessary delay. Benefits will be payable directly to you, as owner of the certificate, unless you specifically request direct payment to the hospital at the time you submit your claim.

BENEFITS ARE PAID EVEN WHEN YOU ARE HOSPITALIZED AT GOVERNMENT EXPENSE

AFA coverage may be purchased by military personnel, and full benefits of your plan are payable even though the insured, or his family members, may be hospitalized in a military or VA institution at government expense.

PROVISION FOR PRE-EXISTING CONDITIONS

Health conditions for which the insured has received medical treatment or advice or has taken prescribed drugs or medicine within 12 months prior to the effective date of his insurance, are considered to be pre-existing conditions. Coverage for such pre-existing health conditions will begin after 12 consecutive months during which he is covered under the policy and receives no medical treatment or advice and takes no such prescribed drugs or medicine.

EXCEPTIONS

Your Plan does not cover losses resulting from (1) hospital confinement commencing prior to the date the protected person or eligible dependent becomes insured under this certificate; (2) declared or undeclared war or act of war; (3) service in the armed forces of any country, except the United States; (4) acts of intentional self-destruction or attempted suicide while sane or insane; (5) pregnancy, including childbirth or resulting complications; (6) confinement in any institution primarily operated as a clinic, convalescent home, rest home, nursing home, or home for the aged, drug addicts, or alcoholics, or hospitalization involving nervous or mental disorders where no charge is made for the expense of confinement.

RENEWAL PROVISION

As long as the Master Policy with AFA remains in force, termination of your coverage can occur only if premiums for coverage are due and unpaid, or if you are no longer an AFA member. Your certificate cannot be terminated because of the number of times you receive benefits.

BENEFIT PAYMENTS MADE IN ADDITION TO OTHER INSURANCE

Benefits will be payable under AFA's Hospital Indemnity Insurance whether or not you are currently insured under some other form of income or hospitalization insurance. If you carry such other insurance (or are entitled to receive government benefits), your AFA Plan will still provide the full, tax-free benefits of the plan you select. *Benefits under your Plan are not considered to be taxable income,* as provided for under regulations of the Internal Revenue Code. However, because benefits are tax free, premiums for this coverage are not tax deductible.

AFA SENIOR AGE BENEFITS

Payable in addition to the hospital benefits of Medicare.

Members age 65 and over may qualify for coverage under the Federally sponsored Medicare program. The hospital benefits of Medicare currently provide coverage in excess of $68.00 during the first 60 days of hospitalization; during the following 30 day period, Medicare pays for eligible charges over $17.00 a day; for hospitalization in excess of 90 days, Medicare benefits are available only when you utilize the 60-day "lifetime reserve", and in this event, your costs become $34.00 a day.

In order to help cover those costs not paid by the hospital benefits of Medicare, AFA Senior Age Benefits are available to all members age 65 and over. It provides daily benefits for as long as 365 days. Benefits for the first 90-day period, during which Medicare coverage is available, is identical for all senior age policyowners—$10.00 a day for the first 60 days and $15.00 a day for the 61st through the 90th day of hospitalization. Daily benefits for coverage beyond the 90th day are available in different amounts ($20.00, $40.00 or $60.00 a day) depending on your choice of plan.

PREMIUM SCHEDULE

	Member's Attained Age	Plan A-1 Member: $20 per day Annual	Plan A-1 Semi-annual	Plan B-1 Member: $40 per day Annual	Plan B-1 Semi-annual	Plan C-1 Member: $60 per day Annual	Plan C-1 Semi-annual
Individual Plan	Under 40	$ 31.80	$16.50	$ 57.00	$ 29.50	$ 84.00	$ 43.00
	40-49	$ 39.00	$20.50	$ 72.00	$ 37.00	$105.00	$ 53.50
	50-59	$ 56.00	$29.00	$106.00	$ 54.00	$156.00	$ 79.00
	60-64	$ 81.00	$41.50	$156.00	$ 79.00	$231.00	$116.50
	65 & over*	$ 59.00*	$30.50*	$ 65.00*	$ 33.50*	$ 72.00*	$ 37.00*
Limited Family Plan	Member's Attained Age	Plan A-2 Member: $20 per day Spouse: $15 per day Annual	Plan A-2 Semi-annual	Plan B-2 Member: $40 per day Spouse: $30 per day Annual	Plan B-2 Semi-annual	Plan C-2 Member: $60 per day Spouse: $45 per day Annual	Plan C-2 Semi-annual
	Under 40	$ 63.00	$32.50	$113.00	$ 57.50	$164.00	$ 83.00
	40-49	$ 76.00	$39.00	$140.00	$ 71.00	$204.00	$103.00
	50-59	$109.00	$55.50	$207.00	$104.50	$304.00	$153.00
	60-64	$156.00	$79.00	$301.00	$151.50	$446.00	$224.00
	65 & over*	COVERAGE ONLY AVAILABLE UNDER INDIVIDUAL PLAN					
Full Family Plan	Member's Attained Age	Plan A-3 Member: $20 per day Spouse: $15 per day Children: $10 per day Annual	Plan A-3 Semi-annual	Plan B-3 Member: $40 per day Spouse: $30 per day Children: $20 per day Annual	Plan B-3 Semi-annual	Plan C-3 Member: $60 per day Spouse: $45 per day Children: $30 per day Annual	Plan C-3 Semi-annual
	Under 40	$ 78.00	$40.00	$142.00	$ 72.00	$206.00	$104.00
	40-49	$ 91.00	$46.50	$169.00	$ 85.50	$246.00	$124.00
	50-59	$125.00	$63.50	$235.00	$118.50	$346.00	$174.00
	60-64	$172.00	$87.00	$331.00	$166.50	$490.00	$246.00
	65 & over*	COVERAGE ONLY AVAILABLE UNDER INDIVIDUAL PLAN					

*Coverage for members age 65 and over is only provided through the AFA Senior Age Benefits Program (see details above) under the individual plan. In the event you become age 65 while insured under the basic program, your coverage will be transferred automatically to the AFA Senior Age Benefit [illegible] on the first renewal

NOTE: Your premium is automatically adjusted to the rate for your attained age on renewal.

UNDERWRITTEN BY: Mutual [illegible] Insurance Company, Home Office: Omaha,

TEAR OFF ALONG PERFORATION • FOLD, SEAL AND MAIL

APPLICATION FOR AFA HOSPITAL INDEMNITY INSURANCE

Underwritten by Mutual of Omaha Insurance Company • Home Office: Omaha, Nebraska

NAME (Please Print) May V. Wilson

ADDRESS 3212-B East 6th Avenue

CITY Hibbing STATE Minnesota ZIP 55746

DATE OF BIRTH May 12, 1926 AGE 47 HEIGHT 5'2" WEIGHT 110

PLAN OF INSURANCE (Check One)

Member Only	☐ A-1	☐ B-1	☒ C-1
Member & Spouse	☐ A-2	☐ B-2	☐ C-2
Full Family	☐ A-3	☐ B-3	☐ C-3

METHOD OF PAYMENT (Check One)

☒ Annual
☐ Semi-Annual

I enclose my initial premium in the amount of $105.00 (Please refer to premium table to determine correct amount.)
check no. 280 enclosed

This insurance coverage may only be issued to AFA members. Please check the appropriate box below:

☒ I am currently an AFA Member

☐ I enclose $10 for annual AFA membership dues (Includes subscription ($9) to AIR FORCE Magazine)

If this application requests coverage for dependents (Limited Family Plan or Full Family Plan) please complete the following information and list only those persons for whom you are requesting coverage.

DEPENDENT'S FULL NAME	RELATIONSHIP TO INSURED	SEX	DATE OF BIRTH
NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE

In applying for this coverage I understand and agree that (a) coverage shall become effective on the last day of the calendar month during which my application together with the proper premium amount is mailed to AFA, (b) only hospital confinements commencing after the effective date of insurance are covered, and (c) any conditions for which I or my eligible dependents received medical treatment or advice or have taken prescribed drugs or medicine within twelve months prior to the effective date of this insurance will not be covered until the expiration of twelve consecutive months of insurance coverage without medical treatment or advice or having taken prescribed drugs or medicine for such conditions.

☒ Yes ☐ No

DATE June 29, 1973 SIGNATURE May V. Wilson

May V. Wilson MAJOR USAF RET.

Application must be accompanied by check or money order.
Send remittance to: sent as Certified Mail #900415, Return Receipt Requested
Insurance Division, AFA, 1750 Pennsylvania Avenue, N.W., Washington, D.C. 20006

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Air Force Association

HOSPITALIZATION · INCOME · INSURANCE

May V. Wilson
NAME OF INSURED

05080
CERTIFICATE NUMBER

June 30, 1973
EFFECTIVE DATE

$105.00
PREMIUM

Annual
MODE OF PAYMENT

INSURED DEPENDENTS: Only those eligible dependents whose names appear on the application (Form 2332MGC App) attached to this certificate shall be insured. Any child born after the effective date of this certificate shall automatically be insured fourteen days after birth providing: (a) a premium is being paid for children's coverage, and (b) such child is not in the hospital on the fourteenth day.

DAILY BENEFIT

MEMBER under age sixty-five $60.00

SPOUSE under age sixty five..$XXXXX

EACH CHILD.....$XXXXX

Medicare Supplemental Benefits are available after age sixty-five. See Termination provision.

The person named above (hereinafter called the protected person) and certain specified dependents are insured under Group Policy Number GMG-6900 (herein referred to as the policy) issued to the Air Force Association (hereinafter called the Policyholder) subject to the terms and conditions of the policy for the amount of Daily Benefit as specified above.

The policy is delivered in the District of Columbia and is governed by the laws of that jurisdiction.

The insurance evidenced by this certificate is provided under and is subject to all provisions of the policy, certain of which provisions are set forth in this certificate.

UNDERWRITTEN BY
MUTUAL OF OMAHA INSURANCE COMPANY
OMAHA, NEBRASKA

T. J. Stutt
Secretary

Form 2332MGC Rev. 6-72

1049

PART A. DEFINITIONS

"Hospital" means a place licensed (if licensing is required by law) as a hospital and operated for the care and treatment of resident inpatients, with a registered graduate nurse always on duty and with a laboratory and an operating room (both on the premises) where major surgical operations are performed by persons legally qualified to do so. In no event shall the term "hospital" mean an institution or that part of an institution which is used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, drug addicts or alcoholics.

For the purpose of paying benefits for nervous or mental disorders, "hospital" also means a place, other than a convalescent, nursing or rest home, which has accommodations for resident bed patients, facilities for the treatment of nervous or mental disorders and a resident psychiatrist always on duty, and which as a regular practice charges the patient for the expense of confinement.

"Injuries" or "Sickness" means any bodily injuries, sickness or disease except that for which the protected person or eligible dependent has received medical treatment or advice or has taken prescribed drugs or medicines within twelve months prior to the date such protected person or dependent became insured under the policy.

Coverage for such preexisting sickness or injury will commence after twelve consecutive months during which the protected person or dependent is covered under this certificate and receives no such medical treatment or advice or takes no such prescribed drugs or medicines.

PART B. BENEFITS

If, because of injuries or sickness and while insured under the policy, a protected person or an eligible dependent is confined as resident patient in a hospital and is under the care of a legally qualified doctor of medicine, the Company will pay the applicable Daily Benefit each day (specified on the face of this certificate), but not to exceed three hundred sixty-five days for any one period of hospital confinement.

Successive periods of hospital confinement shall be considered one period of hospital confinement unless the subsequent confinement commences more than three months after the previous confinement or unless the subsequent confinement is due to causes entirely unrelated to the causes of the previous confinement.

PART C. EXCLUSIONS AND LIMITATIONS

The insurance provided under the policy does not cover losses resulting from: (a) hospital confinement commencing prior to the date the protected person or eligible dependent becomes insured under the policy; (b) declared or undeclared war or act of war; (c) service in the armed forces of any country, except the United States; (d) acts of intentional self-destruction or attempted suicide while sane or insane; (e) pregnancy (including childbirth or resulting complications) or (f) confinement in any institution primarily operated as a home for the aged or engaged in the care of drug addicts or alcoholics.

PART D. GENERAL PROVISIONS

1. **Dependent Insurance.** Eligible dependents shall include the protected person's spouse (providing such spouse is under age sixty-five at the time the member makes application for dependent insurance) and the protected person's unmarried children, excluding in any case:

(a) a child less than fourteen days or who has attained his nineteenth birthday, except that unmarried children who are nineteen but less than twenty-three years of age are eligible if they are wholly dependent upon the protected person for support and maintenance and their time is devoted principally to attending school or college,

(b) the spouse of the protected person, if legally separated from the protected person, and

(c) any dependent who is eligible for insurance under the policy as a protected person.

If both husband and wife are insured under the policy as protected persons, children may be insured as dependents of the husband or wife, but not both.

A protected person's children shall include any stepchildren, legally adopted children and foster children, provided such children are dependent upon the protected person for support and maintenance.

If a protected person makes application for dependent insurance in his original application for insurance, such dependent insurance shall become effective on the date the protected person's insurance becomes effective, provided the proper premium is submitted to the Air Force Association. If the protected person makes application for insurance for dependent coverage after the date his insurance becomes effective, insurance for such dependent shall become effective on the last day of the policy month during which the application for insurance and the proper premium are submitted to and accepted by the Air Force Association.

2. **Termination of Insurance.** The insurance of any protected person shall terminate on whichever of the following dates occurs first:

(a) The first premium due date following the date the protected person attains age sixty-five, unless the required premium for Medicare Supplement Insurance is submitted within thirty-one days of such date,

(b) The date a protected person's dues to the Air Force Association are not fully paid,

(c) The date any required premium payment is due and unpaid, or

(d) The date the Master Policy terminates.

The insurance of any dependent shall terminate on whichever of the following dates occurs first:

(a) The date such dependent ceases to be an eligible dependent,
(b) The date the protected person's insurance terminates hereunder,
(c) The first premium due date following the date the protected person attains age sixty-five (the dependent spouse and any eligible children may obtain Hospitalization Income Insurance by notifying the Air Force Association within thrity-one days of the date of such termination),
(d) The first premium due date following the date the dependent spouse attains age sixty-five (such dependent spouse may become insured for Medicare Supplement Insurance provided the required premium is submitted within thirty-one days of such premium due date),
(e) The date any required dependent premium payment is due and unpaid, or
(f) The date the Master Policy terminates.

3. Not In Lieu of Workmen's Compensation. The policy is not in lieu of and does not affect any requirement for coverage by workmen's compensation insurance.

PART E. UNIFORM PROVISIONS

1. Entire Contract; Changes. The policy, the application of the Policyholder and the individual applications, if any, of the protected persons constitute the entire contract between the parties, and any statement made by the Policyholder or by any protected person shall be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the policy or be used in defense to a claim hereunder unless it is contained in a written application signed by the Policyholder or the protected person, a copy of which has been furnished to such Policyholder or to such person or his beneficiary.

No change in the policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the policy or to waive any of its provisions.

2. Time Limit on Certain Defenses. After two years from the date of issue of the policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his application shall be used to void the policy; and after two years from the effective date of the coverage with respect to which any claim is made, no misstatement of any protected person eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability commencing after expiration of such two years.

3. Notice of Claim. Written notice of claim must be given to the Company through the Air Force Association within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behelf of the claimant to the Air Force Association with information sufficient to identify the insured protected person shall be deemed notice to the Company.

4. Claim Forms. The Air Force Association, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurence, the character and the extent of the loss for which claim is made.

5. Proofs of Loss. Written proof of loss must be furnished to the Company through the Air Force Association within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

6. Time of Payment of Claims. Indemnities payable under the policy for any loss will be paid as they accrue immediately upon receipt of due written proof of such loss.

7. Payment of Claims. All indemnities will be payable to the insured protected person.

Subject to any written direction of the insured protected person in an application or otherwise, all or a portion of any indemnities provided by the policy on account of hospital service may, at the Company's option and unless the insured protected person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital, but it is not required that the service be rendered by a particular hospital.

8. Physical Examinations and Autopsy. The Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

9. Legal Actions. No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

10. Conformity with State Statutes. Any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which the policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 81-2102

September Term 1981

May V. Wilson,

Petitioner,

vs.

Robert G. Renner, United States District Judge for the Third Division, District of Minnesota,

Respondent.

Petition for Writ of Mandamus

To the Honorable United States Circuit Judges of the 8th Circuit Court of Appeals:

The Petitioner, May V. Wilson, hereinafter referred to as the Plaintiff, respectfully shows:

1. STATEMENT OF FACTS: Plaintiff purchased a large number of daily hospital benefit policies through the mails. These are group policies which provide for guaranteed acceptance, and, after a waiting period, they cover preexisting conditions. Each policy pays a fixed amount for each day of hospitalization if:

a. The Plaintiff is sick, and

b. Inpatient hospitalization is reasonably required. Certain types of sickness are excluded but none are rele-

vant in this action. Also the policy requires that the treating doctor be a qualified physician, and that the hospital be a general medical hospital (these also are not relevant in this action).

Plaintiff had three policies with Defendant, Mutual of Omaha Insurance Company. Each one was a group policy through her memberships in the American Automobile Association for Uniformed Services.

This particular claim involves two hospitalizations. One occurred from September 5, 1977 to October 21, 1977, and the second was from April 13, 1978 to June 9, 1978. Both hospitalizations were at the Metropolitan Medical Center, a major hospital in downtown Minneapolis. Both hospitalizations were under the care of a psychiatrist, Dr. Randall Lakosky, a psychiatrist licensed to practice in Minnesota and associated with the Metropolitan Medical Center. Defendant was timely notified of the hospitalizations. At no time during the pendency of Defendant's consideration of this claim, nor at any time during the processing of this lawsuit did Defendant request that Plaintiff submit to an adverse medical exam, until almost three (3) years after the second hospitalization. Then, under cover of letter dated March 31, 1981, they sought to have Plaintiff submit to an adverse psychiatric examination.

Psychiatric conditions are sensitive, personal matters which have received increased attention and protection from our courts in recent years. In some cases, an insurer's right to inquire into the party's state of mind has been restricted in order to protect the personal, intimate relationship between a psychiatrist and his patient. The nature of the relationship is such that full patient-doctor

disclosure and effective treatment cannot be obtained without assuring the patient that his revelation of intimate details will not be made available to third parties, without demonstration of substantial needs. So for example, in *Schlagenhauf v. Holder*, 379 U.S. 104, 85 Supreme Court 234 (1964), a writ of certiorari issued because movant failed to show good cause for a mental examination. And in *Metropolitan Life Insurance Company v. Lehman*, 125 Georgia Ap. 539, 188 S.E.2d 393 (1972), the Court denied the insurer a right to a medical exam where the insurer could have obtained the desired information "by other means", presumably through deposition questioning of a doctor who had examined the insured. See also *Marroni v. Matey*, 82 FRD 371 (1979), and *Winters v. Travia*, 18 Federal Rules Service 2d 842 (1974), and *Bodner and Bodner*, 441 F2d 1103, Cert. Denied, 404 U.S. 913, 92 Supreme Court 232 (1971).

Defendants herein have made no attempt to take the deposition of the treating doctor.

2. ISSUES:

A. Has Defendant shown good cause to require Plaintiff to submit to an invasive psychiatric examination.

B. Should Defendant be required to examine the hospital and office records of the treating doctor and take his deposition prior to seeking an adverse psychiatric examination.

C. Does Defendant have a right to an adverse psychiatric examination three years after the hospitalization in issue, particularly when the medical issues involved under this type of policy are so limited.

D. Where Defendant did not request a timely medical examination while the claim was being considered, and prior to denial of the claim, is it entitled to an adverse examination at this late stage of the proceedings.

3. RELIEF SOUGHT:

A. That the order of Judge Renner, dated July 23, 1981, be quashed.

B. That Defendant has waived its right to an adverse psychiatric examination relative to the medical issues under these insurance policies.

4. REASONS WHY WRITS SHOULD ISSUE: A writ should issue to protect Plaintiff from an evasive examination. Information developed as a result of such an exam will find its way into the hands of Defendant insurance company, may be attached to public court records, and may be distributed by Defendant to claims people and other third persons. Accountability for distribution is impossible. In addition, it is an invasion of Plaintiff's privacy, to permit such an examination under the circumstances of this case. Given the limited nature of the medical issues involved, it is unquestionably unnecessary and an intimidating experience for persons such as Plaintiff, seeking only to be paid the fixed policy benefits.

Furthermore, it might also be noted here that whether an adverse doctor agrees or disagrees with the treating doctor's determination to treat Plaintiff in a hospital is not the relevant inquiry. The factual inquiry, to the extent that one exists, is whether or not a qualified doctor could reasonably conclude to treat Plaintiff in a hospital. Plaintiff bought these policies to provide coverage in the

event that she was subjected to lengthy debilitating hospitalizations. Her coverage should not now be subjected to challenges based on the fact that some doctors would not have treated her in the same way. If this was one reasonable way to treat her, then the coverage should follow. Based on this rationale, Defendant could take the treating doctor's deposition and ascertain the basis for his hospitalization. Then an adverse doctor could review the deposition and determine whether or not he agreed that this was a reasonable course of treatment.

5. Attachments:

    1. Complaint,
    2. Answer,
    3. Copies of policies and advertisements,
    4. Defendant's motion papers,
    5. Plaintiff's memorandum in opposition to the motion,
    6. Order of Magistrate E. Cudd, and
    7. Order of Judge Robert G. Renner.

Dated: 10/14, 1981.

PETERSON, ENGBERG & PETERSON
THOMAS W. WEXLER
Attorney for Petitioner

Answer to the Petition for a Writ of Mandamus

TO: THE HONORABLE UNITED STATES CIRCUIT JUDGES OF THE EIGHTH CIRCUIT COURT OF APPEALS:

COMES NOW, Mutual of Omaha Insurance Company, and for its answer to the Petition, states as follows:

1. Mutual of Omaha Insurance Company is not a named party in these proceedings, but files this answer by direction of the Court of Appeals.

2. The underlying litigation between May V. Wilson and Mutual of Omaha Insurance Company is one of a series of lawsuits filed by Petitioner in Hennepin County District Court and the United States District Court for the District of Minnesota. See *May V. Wilson vs. Colonial Penn Life Insurance Company* (U.S.D.C. Minn. 1978) 54 F.Supp. 1208.

3. This litigation concerns several of sixty or more policies or certificates of daily hospital indemnity insurance purchased by or on behalf of the Petitioner. The policies pay so much per day for every day the insured is necessarily confined in a hospital. In aggregate, Petitioner has made substantial claims for a number of extended hospital stays in the United States, Mexico and Costa Rica.

4. The hospitalizations involved in the underlying litigation were in 1977 and 1978 in Minneapolis and concerned treatment for an alleged *psychiatric* condition. Suit was commenced in 1980 and Mutual of Omaha has answered alleging, inter alia, that the policies or certificates were purchased pursuant to a wager scheme and that the alleged hospitalization was not reasonably necessary.

5. In a timely fashion, Mutual of Omaha requested an adverse medical examination pursuant to both the terms of Rule 35 and the policy provisions, for example:

> "The company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law." (AFA Policy).

Considering the psychiatric nature of Petitioner's claimed sickness, Mutual of Omaha scheduled the adverse medical examination with a psychiatrist. Petitioner resisted and the discovery order for the examination resulted. Attempts made by Mutual of Omaha to schedule the examination following issuance of the discovery order have been frustrated by Petitioner and, rather then comply with the order, this Petition for Writ of Mandamus resulted.

6. By claiming benefits for hospitalization, Petitioner has placed her physical and mental condition in issue. In order to prevail at trial, she will need expert medical testimony that the hospitalization was reasonably necessary for treatment of a sickness. Mutual of Omaha presumes that Petitioner will be calling on her behalf her treating physician, Dr. Randall Lakosky. Mutual of Omaha needs to meet the anticipated testimony of Dr. Lakosky with expert testimony in its behalf. Thus, the scheduled examination with Dr. Carl Schwartz. Without the examination and testimony of Dr. Schwartz, Mutual of Omaha Insur-

ance Company cannot be expected to properly defend against plaintiff's claim that her hospitalization was reasonably necessary or a sickness.

7. The court below found that Mutual of Omaha made a proper showing of necessity for the adverse medical examination. The order of the Magistrate was appealed to Judge Renner and was affirmed. A writ of mandamus or prohibition should issue only upon a showing of extraordinary circumstances. *Gialde v. Time, Inc.*, 480 F.2d 1295 (8th Cir. 1973). If such circumstances exist. Mutual of Omaha is unable to discern what they are other than Petitioner's reluctance to have her claims scrutinized. Petitioner simply disagrees with an order which is normally routine. In fact, adverse medical examinations are ordinarily conducted without resort to the courts.

8. In the context of Rule 35, the United States Supreme Court in *Schlagenhauf v. Holder*, 379 U.S. 104. 85 S.Ct. 234, made it clear that a writ of mandamus should not issue absent "a substantial allegation of usurpation of power." 279 U.S. at 411, 85 S.Ct. at 239. Such an allegation has not been made here. Nor has Petitioner shown a clear abuse of discretion on the part of the trial court. In fact, the denial of an adverse medical examination under the circumstances of the underlying litigation would probably be an abuse of discretion.

WHEREFORE, Mutual of Omaha Insurance Company prays for an order denying the Petition for Writ of Mandamus.

CRAGG & BAILLY, LTD.
By ROBERT S. CRAGG
Attorneys for Mutual of Omaha
Insurance Company